

financial records and statistical data for proper determination of costs payable by CMS for covered services the HMO or CMP furnished to its Medicare enrollees either directly or under arrangements with others. These include accurate and sufficient detail of incurred costs and enrollment data.

(2) Unless otherwise provided for in this subpart, the HMO or CMP must follow standardized definitions and accounting, statistics, and reporting practices that are widely accepted in the health care industry.

(b) *Provision of data.* (1) The HMO or CMP must provide adequate cost and statistical data, based on its financial and statistical records, that can be verified by qualified auditors.

(2) The cost data must be based on an approved method of cost finding and, except as provided in paragraph (b)(3) of this section, on the accrual method of accounting.

(3) For governmental institutions that use a cash basis of accounting, cost data developed on this basis is acceptable. However, only depreciation on capital assets, rather than the expenditure for the capital asset, is allowable.

(c) *Provider services furnished directly by the HMO or CMP.* If the HMO or CMP furnishes provider services directly, the provider is subject to the cost-finding and cost-reporting requirements set forth in parts 412 and 413 of this chapter. The provider must use an approved cost-finding method described in §413.24 of this chapter to determine the actual cost of these covered services.

(d) *Supplier services furnished directly by the HMO or CMP.* If the HMO or CMP furnishes Part B physician and supplier services directly, it must furnish statistics that indicate the frequency and type of service provided, in the form and detail prescribed by CMS.

(e) *Part B physician and supplier services furnished through arrangement.* If the HMO or CMP furnishes Part B physician and supplier services under arrangements with others, it must furnish to CMS statistical, financial, and other information with respect to

those services in the form and detail prescribed by CMS.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46231, Sept. 6, 1995]

§417.570 Interim per capita payments.

(a) *Principle of payment.* (1) CMS makes monthly advance payments equivalent to the HMO's or CMP's interim per capita rate for each beneficiary who is registered in CMS records as a Medicare enrollee of the HMO or CMP.

(2) Additional lump-sum payments may be made at other times during the contract period, at CMS's discretion, to adjust the total amounts paid during the contract period to the level of incurred costs.

(b) *Determination of rate.* The interim per capita rate of payment is equal to the estimated per capita cost of providing covered services to the HMO's or CMP's Medicare enrollees, based upon the types and components of costs that are reimbursable under this part. The interim per capita rate is determined annually by CMS on the basis of the HMO's or CMP's annual operating and enrollment forecast (as set forth in §417.572) and may be revised during the contract period as explained in paragraphs (c) and (d) of this section.

(c) *Adjustments of payments.* In order to maintain the interim payments at the level of current reasonable costs, CMS will adjust the interim per capita rate, to the extent necessary, on the basis of adequate data supplied by the HMO or CMP in its interim estimated cost and enrollment reports or on other evidence showing that the rate based on actual costs is more or less than the current rate. Adjustments may also be made if there is—

(1) A change in the number of Medicare enrollees that affects the per capita rate;

(2) A material variation from the costs estimated when the annual operating budget was prepared; or

(3) A significant change in the use of covered services by the HMO's or CMP's Medicare enrollees.

(d) *Reduction of interim payments.* If the HMO or CMP does not submit, on time, the reports and other data required to determine the proper amount

§ 417.572

of payment, CMS may reduce interim payments to the extent appropriate, or may take any other action authorized under this part. An interim payment reduction remains in effect until CMS can make a reasonable estimate of per capita costs.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.572 Budget and enrollment forecast and interim reports.

(a) *Annual submittal.* The HMO or CMP must submit an annual operating budget and enrollment forecast, in the form and detail required by CMS, at least 90 days before the beginning of each contract period. The forecast must be based on financial and statistical data and records that can be verified if CMS requires a detailed review of supporting records. The data and records include, but are not limited to, all ledgers, books, records, and original evidence of costs, and statistical data used in the determination of reasonable cost.

(b) *Effect of failure to submit on time.* If the HMO or CMP does not submit the budget and enrollment forecast on time, CMS may—

(1) Establish an interim per capita rate of payment on the basis of the best available data and adjust payments on the basis of that rate until the required reports are submitted and a new interim per capita rate can be established; or

(2) If there is not enough data on which to base an interim per capita rate, inform the HMO or CMP that interim payments will not be made until the required reports are submitted.

(c) *Interim cost reports.* (1) An HMO or CMP must submit interim cost reports on a quarterly basis in the form and detail prescribed by CMS. These interim cost reports must be submitted no later than 60 days after the close of each quarter of the contract period.

(2) CMS may reduce the frequency of the reports required under paragraph (c)(1) of this section if CMS determines that, on the basis of the HMO's or CMP's reporting experience, there is good cause to do so.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

42 CFR Ch. IV (10–1–13 Edition)

§ 417.574 Interim settlement.

(a) *Determination.* Within 30 days following the receipt of the HMO's or CMP's final interim cost and enrollment reports, CMS will make an interim determination of the estimated amount payable to the HMO or CMP for the reasonable cost of covered services furnished to its Medicare enrollees during the contract period. CMS will base the determination on the interim cost report and enrollment data submitted by the HMO or CMP, and any other relevant data CMS finds appropriate. For this purpose, CMS will accept costs as reported, subject to later review or audit, unless there are obvious errors or inconsistencies.

(b) *Payment.* Any difference between the total amount of interim payments and the amount found payable on the basis of the interim determination under paragraph (a) of this section, must be paid by the HMO or CMP or will be paid by CMS, whichever is appropriate, no later than 30 days after CMS's determination.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.576 Final settlement.

(a) *General rule.* Final settlement and payment of amounts due the HMO or CMP or the appropriate Medicare trust funds are made following the HMO's or CMP's submission and CMS's review of an independently certified cost report and supporting documents as described in paragraph (b) of this section.

(b) *Certified cost report as basis for final settlement—*(1) *Timing of cost report.* The HMO or CMP must submit to CMS an independently certified cost report and supporting documents, in the form and detail required by CMS, no later than 180 days after the end of each contract period, unless CMS extends the period for good cause shown by the HMO or CMP.

(2) *Content of cost report.* The cost report and supporting documents must include the following:

(i) The per capita costs incurred in furnishing covered services to its Medicare enrollees, determined in accordance with subpart O of this part and including—